STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146026	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Sangamon Valley	3400 West Washington Springfield, IL 62711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview the facility failed to notify a resident's responsible party of a resident injury for 1 of 4 residents (R3) reviewed for notification in the sample of 6.Findings Include:R3's medical diagnosis sheet, print date of 7/23/25, documented R3 has diagnoses including unspecified severe dementia with agitation, dysphagia, osteoporosis, crest syndrome, anemia, and congestive heart failure. R3's MDS (Minimum Data Set), dated 6/23/25, documented R3 is severely cognitively impaired and is dependent on staff for ADLS (activities of daily living). R3's progress note, dated 7/10/25 at 11:57 PM, documented CNA (Certified Nurse Assistant) made writer aware that resident had smashed her finger in the door. 4th digit of right hand observed to have the door indention print, redness and what look like a bruise forming. POA/MD (Power of Attorney/Medical Doctor) updated. On 7/22/25 at 10:27 AM V4, private caretaker for R3, stated last week on 7/11/25 during one of her visits to see R3 as she was washing R3's hands she noticed her right hand was bruised, swollen, and had a small skin tear. V4 stated she went to R3's nurse and CNA on the day shift and they both said they didn't know anything about R3's bruised hand. V4 stated then an evening shift CNA named (V5) came in at the beginning of her shift and said to her how is (R3's) hand, and that she was the one who found R3 with her hand stuck in the door across the hall from R3's room yesterday evening (7/10/25). V4 stated V5 told her that R3 was yelling help when she found her with her hand stuck in the door and that she took her to R3's nurse who was an agency nurse to have her hand looked at. V4 stated the next day R3 had an x-ray, and it was negative. V4 stated POA/daughter in California was not notified of the incident that evening nor did she know about it the next day when V4 first observed the injury. On 7/22/25 at 1:33 PM V9, daughter/POA for R3, stated she was never notified by the facility of R3's hand injury. V9 stated (V4) the personal caretaker she hired to look after her mom called her on 7/11/25 and informed her of the injuries she observed on her mom's right hand. V9 stated she then called the facility on 7/11/25 and asked her mom's nurse about the injury to her mom's hand. V9 stated her nurse did not know anything about the injury and the nurse said she didn't get anything in report from the night nurse about any injuries to her mom. V9 stated she then spoke to the DON (Director of Nursing) and the DON (V2) said the nurse documented she called and informed (V9). V9 stated she informed V2 she did not get any calls from the facility, she checked her phone, and did not have any missed calls from the facility. V9 stated she is a physician, and this concerned her due to the lack of supervision and monitoring of her mom.On 7/22/25 at 1:55 PM Surveyor asked V2, DON, if R3's skin condition report, dated 7/11/25 at 3:11 PM, was considered the incident report for R3's hand injury when she got her hand stuck in the door. V2 answered the night nurse did not complete an incident report on that. Surveyor asked V2 if the night nurse should have completed an incident on R3's hand injury and V2 replied yes. Surveyor asked if the night nurse called R3's family/contact person the night R3 injured her hand. V2 replied she charted she called but she said she got busy and didn't call. V2 stated I gave her a verbal warning for that.On 7/23/25 at 10:48 AM V1, Administrator, stated the facility nurses are expected to complete an incident report and call the POA when a resident sustains an injury.The facility's Incident and Accidents policy, dated 10/2024, documented the Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents, or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors, or other, and resident-to-resident altercations. Procedure: An 'incident' is defined as any happening, not consistent with the routine operation of the facility, that does not result in bodily or property damage. Physical or mental mistreatment of a resident is considered an incident whether or not actual injury has occurred. An 'accident' is defined as any happening, not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/accident report will be completed for: 1. All serious accidents or incident of residents. 2. All injuries of staff, families, and visitors. 3. All unusual occurrences. 4. All situations requiring the emergency services of a hospital, the police, fire department, or coroner. 5. Any type of resident abuse. 6. All unexpected events that occur that cause actual or potential harm to a resident or employee. 7. Suicide or attempted suicide. 8. Leaving premises without authorization. 9. Any condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility. 1. An incident/accident report is to be completed by a RN or LPN and is to include: a. Date and time of an incident/accident. b. Full written statement and possible cause of incident, physical assessment, injuries noted, vital signs, treatment rendered, and notification of appropriate parties. 2. An RN or LPN must notify the following if an actual injury occurs: a. Physician b. Legal representative, or interested family member within 24 hours

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, observation, and record review, the facility failed to properly supervise 2 of 3 residents (R2, R3) reviewed for incidents and accidents in the sample of 6. This failure resulted in a resident (R2) to fall in an office rest room that was left unlocked after the office staff left for the day and R2 was not found for approximately 2.5 hours after staff noticed him missing. The facility also failed to complete an incident report per its policy after R3 sustained an injury when she got her hand stuck in a door and did not add an intervention to R3's care plan until 12 days after R3's incident. Findings Include:R3's medical diagnosis sheet, print date of 7/23/25, documented R3 has diagnoses including unspecified severe dementia with agitation, dysphagia, osteoporosis, crest syndrome, anemia, and congestive heart failure.R3's MDS (Minimum Data Set), dated 6/23/25, documented R3 is severely cognitively impaired and is dependent on staff for ADLS (activities of daily living).R3's progress note, dated 7/10/25 at 11:57 PM, documented CNA (Certified Nurse Assistant) made writer aware that resident had smashed her finger in the door. 4th digit of right hand observed to have the door indention print, redness and what look like a bruise forming. POA/MD (Power of Attorney/Medical Doctor) updated.On 7/22/25 at 10:27 AM V4, private caretaker for R3, stated last week on 7/11/25 during one of her visits to see R3 as she was washing R3's hands she noticed her right hand was bruised, swollen, and had a small skin tear. V4 stated she went to R3's nurse and CNA on the day shift and they both said they didn't know anything about R3's bruised hand. V4 stated then an evening shift CNA named (V5) came in at the beginning of her shift and said to her how is (R3's) hand, and that she was the one who found R3 with her hand stuck in the door across the hall from R3's room yesterday evening (7/10/25). V4 stated V5 told her that R3 was yelling help when she found her with her hand stuck in the door and that she took her to R3's nurse who was an agency nurse to have her hand looked at. V4 stated the next day R3 had an x-ray, and it was negative. V4 stated POA (Power of Attorney)/daughter in California was not notified of the incident that evening nor did she know about it the next day when V4 first observed the injury. On 7/22/25 at 1:33 PM V9, daughter/POA for R3, stated she was never notified by the facility of R3's hand injury. V9 stated (V4) the personal caretaker she hired to look after her mom called her on 7/11/25 and informed her of the injuries she observed on her mom's right hand. V9 stated she then called the facility on 7/11/25 and asked her mom's nurse about the injury to her mom's hand. V9 stated her nurse did not know anything about the injury and the nurse said she didn't get anything in report from the night nurse about any injuries to her mom. V9 stated she then spoke to the DON (Director of Nursing) and the DON (V2) said the nurse documented she called and informed (V9). V9 stated she informed V2 she did not get any calls from the facility; she checked her phone and did not have any missed calls from the facility. 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